

Measuring the Welfare Impact of Public Expenditure on Primary Healthcare Services in Rural Nigeria

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Abstract

In this study, attempt has been made to measure the welfare impact of public expenditure on primary healthcare services in rural Nigeria employing the benefit-incidence approach. Primary and secondary data were generated from various healthcare centres and samples selected from various localities in Ika South Local Government Area of Delta state. From the sample selected, households were decomposed into non-poor, moderately poor and core poor. An analysis of the data depicts that the non-poor benefited more from the public primary healthcare services. The low benefit accruing to the poor group is attributable to their relative inaccessibility to access public healthcare in terms of drugs and consultation. There is therefore the need for proper implementation of primary healthcare policies to make them more pro-poor.

Keywords: Public expenditure, Healthcare services, Welfare impact, Benefit-incidence analysis

1. Introduction

The desire of Nigeria and 199 other countries of the World while signing the Millennium Development Goals (MDGs) is to work within 15 years to improve the health status of their citizens by setting specific target on child mortality, maternal health and other health outcomes. Towards achieving these goals, government of various countries have introduced policies, programmes and carried out expenditure on various healthcare facilities. However, achieving improved healthcare would be a mere wishing thinking without radically refocusing the health sub-sectors for effective service delivery to ensure efficiency (Wagstaff and Cleason 2004). The attainment of better healthcare condition is imperative in the growth process of an economy because of the widely held view that there is a close link between health conditions and wealth of a nation. This view was collaborated by Pritchett and Summer (1996) and Mwabu (1998) when they asserts that developed nations have been able to attain viable positions in human development indices, wealth creation and growth due largely to the provision of better health services to the people.

However, in many developing countries like Nigeria, low health status is still a major problem and this has been further aggravated by widespread HIV/AIDS epidemic, which has already killed millions of people. In 2001 alone, 170,000 adults and children died of AIDS. Also between 1995 and 2015, it is projected that malnutrition and other easily preventable childhood diseases would kill about 1.8 million children tuberculosis another 2.5 million people and malaria 740,000 (Murray and Lopez 2006). All these, coupled with wide spread poverty, corruption, insecurity, hunger and poor economic growth combined to depict an unsavory picture of the poor health status of majority of Nigerians.

In Nigeria, despite increased public health spending and some improvement recorded in some health indicators, Nigeria still has persistent economic stagnation which aids rapid deterioration of healthcare among other essential services. Ayorinde and Aregbeyen (2002) states that, "out of 115 countries, Nigeria ranked 74th based on the performance of some selected health indicators. Nigeria's rate of infant mortality (100 per 1000 live births) is among the highest in the world". In 2000, the maternal mortality ratio in Nigeria was 800 per 100,000 live births which rose further to 100 per 100,000 in 2010. This increase in maternal mortality rate has had negative effect on other health outcomes. For instance, the infant mortality which was measured at 87 in 1990 was evaluated at 100 per 1000 in 2003. Infant deaths, which accounted for half of child mortality, have risen from what they were in 1990 (WHO 2013). With 13 percent immunization rate for children between 12-23 months, Nigeria has been described by World Health Organization as the African country with the lowest vaccination rate. According to World Bank (2010) and United Nations (2010), not more than 40 percent of the population has access to modern health services. Moreover, there is inappropriate orientation of investment between curative and preventive services, inefficiency in the management of health resources and inadequate community involvement

It is imperative to state that lack of improvement in health conditions in Nigeria is due largely to inadequate coverage. These, coupled with inadequate funding, lack of proper health education, unreliable physical infrastructure and logistic supports further widen the problem of the dimensions. This raises a pertinent concern

that in spite of government promises to increase healthcare services for all Nigerians, the contribution of this sub-sector to factors aiding in the achievement of MDGs is still very minimal. The poor outcome in the performance of many of these services is due to gross inefficiencies and inequalities in the design and implementation and access to these healthcare services. Health development, which indisputably forms a process of sustained improvements in health status, must, therefore, be an important target of development policy.

It is for this reason, among others that studies have been conducted on the relationship between government expenditure and healthcare at the federal level of government. Eventhough this aggregate analysis is a useful approach, it offers little help in policy initiatives and actions, such an approach therefore does not provide a comprehensive analysis of efforts by sub-national levels so far towards improving healthcare services. Besides, current thinking suggests that the purpose of development is to widen and deepen the range of choices and opportunities open to people. In the light of the above, this study presents a spatial analysis of the welfare impact of public expenditure on primary healthcare services in Ika South Local Government Area of Delta state using the benefit-incidence approach. The essence is to use the analysis to clearly draw inferences that could inform policies, strategies and interventions to facilitate a quick realization of the millennium development goals, particularly in respect to achieving the goals of health for all Nigerians. Beside, different levels of government in Nigeria- federal, state and local have experienced tremendous growth in public expenditure. Therefore it is absolutely necessary to formulate rational public expenditure synergy in order to achieve the desired effects on public expenditure on improved health conditions of the citizen given the heterogeneous nature of the country. The remainder of this paper proceeds in four steps. First, we present a compendium of primary healthcare in Nigeria. This is followed by the theoretical and methodological framework in section 3 while section 4 is presentation and discussion of the results. The final section is conclusion.

2. Primary Healthcare in Nigeria: A Compendium

Primary healthcare was put in place out of the desire to take healthcare services closer to the people especially those that live in the rural communities in order to achieve better health for all. For the fact that they offers families and communities cost-effective services close to them, primary healthcare plays a great role in reducing hospital and specialists cost and reduces health inequalities among different groups in the society. Accordingly, UNICEF/WHO (1978) sees primary healthcare as essential healthcare anchored on practical, scientifically, sound and socially acceptable and modern techniques made universally accessible and acceptable to individuals and their families in the community through their full participation and at a cost the beneficiaries (individuals, community and country) can easily afford to maintain at every stage of their development to enable the individuals benefit from the opportunities which the development process provides. Put succulently, Bamigboye (2001) asserts that primary healthcare centre is a people-oriented service anchored on the axiom of health of the people, by the people and for the people and not regarded as the exclusive prerogative of health professionals.

According to World Health Organization (WHO), the four essential components of a primary healthcare are:

- (i) Universal coverage by ensuring that medicines and services are adequately and sufficiently supplied at affordable cost to achieve social health protection;
- (ii) People-centered care by transforming traditional healthcare delivery practices into modern acceptable primary people-centered network models;
- (iii) Participatory leadership. This is to encourage a shift from self-centered approaches to increasing participation by all stakeholders; thus moving from supply-led to demand-led policies and programmes;
- (iv) Health in all policies to ensure that all relevant sectors such as individuals, community and education factors are taking into consideration in the design and implementation of health agenda.

In Nigeria, primary healthcare are seen as those services that are delivered in doctor's clinics, special institutions for the handicapped and the disabled, and in patients own home and its policy anchors on the philosophy of social justice and equity. For this reason, it is largely based and adopted for delivery healthcare services to the grassroots designed to provide services on Maternal and child health, provision of essential drugs, appropriate treatment of common diseases, prevention and control of locally endemic diseases, food nutrition, dental health and health education. Although the healthcare services in Nigeria has evolved through a series of policies and plans, it is still bedeviled with a variety of problems such as poor or no community buy-in the running of the healthcare centres, underfunding, insufficient number of qualified personnel, non-accessibility in terms of distance to communities and bad roads leading to some of the centres, non-affordability with regard to drugs and services, among others.

3. Theoretical and Methodological Framework

Economists have long been interested in measuring the benefits derivable from public expenditure. In essence, they are concerned with the evaluation of how government expenditure on public goods affects the welfare of different groups of people or individual households in the society (Demetery, 2003). In doing so, the effectiveness of such spending is put into consideration. From the point of view of organizational theory, effectiveness relates to the attainment of goals towards increasing welfare. In line with this, a hospital is effective, if it successfully meet the goals of its clients at a lower cost monetary terms.

In carrying out expenditure, the principal objective of the government is to maximize social benefit. But the objective of maximum social welfare can only be attained when inequality of income is removed or minimized. This because public expenditure on some services such as education and health have been demonstrated to have positive impact on productivity of the weaker section of society by improving their income earning capabilities.

In this study, attempt is made to measure the welfare impact of public expenditure using the benefit-incidence approach. This approach is adopted because of its capability in demonstrating that the welfare effects from public programmes and expenditure whose aim is to eliminate market constraint predominate those that can be attained through inter-personal income distribution (Holzman 1989). The welfare impact was employed by De Mooji, Sinderen and Gout (1989) to demonstrate that the numerical simulation of the effects of different public expenditures and taxes on welfare varies depending on the means used in financing public investment.

This approach can equally be used to visualize the effect of government expenditure on public goods such as education and health in consideration of who is benefiting from such service. This encompasses a combination of information about the unit cost of providing this service and data generated from households through a sample survey. Thus, the theory and practice of result-oriented public expenditure management relate not only to the benefit accruable from such spending but also how to enhance the welfare of the citizens. We utilize benefit-incidence analysis in this regard because of the fact that not only can it be used to predict how funds should be allocated, but it can also be used to evaluate whether those funds, were actually allocated efficiently. Also, our approach can be used to make inter-state and country comparisons about the efficiency of primary health care funding in Nigeria. Moreover, a benefit incidence approach can be an influential technique in driving home messages of the need for budget allocation and reform. Lastly if one is using the results of benefit-incidence analysis to address policy issues, particularly issues related to the optimal allocation of a fixed amount of resources, then one must compare alternatives, in a relative fashion. Thus, its findings are consistent with the needs of policy makers (Rosenman and Friesner 2004).

The application of benefit-incidence analysis begins by categorizing individuals (households) into group consistent with some form of welfare Quintile such as deciles, by some selected measure of current welfare. It then draws information on individual (household) level of participation in the publicly provided service under consideration to tally up number of beneficiaries in each group. Those numbers are then multiplied by the government unit cost of provision to derive net of fees. Benefit-incidence measures are more comparable with measures of income and expenditure which do not entail consumer surplus. Moreover, they are not based on individuals (households) to changes in public spending.

An initial effort to analyze benefit-incidence by Selowsky (1979) was based on the reported use of government services by households. Combining the information derived from household surveys with information on the cost of providing the services, the incidence of government expenditure can be estimated across household groups. While considering the benefit-incidence of government expenditure on a particular service, the incidence to one group depends on the use of publicly funded services by that group and the distribution of such expenditure. On this, Baldacci, Guin SruMT and de Mello (2002) opines that such benefit will be greater as the government spends more on the services used relatively more by the group. But Prodham and Swaroop (1998; 2003) contend that misallocation of public expenditure remains a problem. They are of the opinion that government expenditure at the tertiary level tend to crowd out basic social services and for this reason, public expenditure should be incorporated into a benefit policy framework. On this, Reinikka (2001) and Howell (2005) suggested that public sector budgeting should allocate scarce resources where there is market imperfection. Such concerns have made more imperative the tracking of the flow of public spending especially in developing countries like Nigeria, from spending to frontline services.

3.1 Nature and Sources of Data

Data generation blends primary survey-based data with secondary information sources. The latter involved the extraction of relevant information from Delta state Ministry of Health. In respect of primary data, a field survey

was conducted using a well-structured questionnaire that elicits information from the users of primary health centres (PHCs) in the local government. The study also employed a multi-stage sampling procedure to select respondents for interviewing. The study is limited to PHCs in Ika South Local Government Area of Delta State. The reason for selecting healthcare services is that it represents a major social service in which the local government has primary responsibility. Even at that, the choice of this social sector is not fortuitous in that healthcare services are basic services essential in any effort to combat poverty and inequality. It is for this reason that healthcare service is often heavily subsidized with public fund to help achieve this goal. Ika South Local Government Area has twelve wards and 17 primary healthcare centres with a Model Primary Health Care at Agbor. Due to the scattered locations of the health centres, a total of 12 PHCs were systematically selected for the study to include all the wards. Areas covered are; Agbor-Obi, Ozanogogo, Aliagwu, Ekuku-Agbor, Oki, Ewuru, Agbor, Emuhu, Oyoko, Obi-Anyima, Abavo Central and Udomi-Azuowa. In all the areas, a total number of 120 households were sampled. Ten instruments were lodged in each centre but 110 were returned, representing a retrieval rate of 91.7 percent. The time and financial resources available for the study dictate the restriction to only 120 respondents. The primary analytical techniques used are descriptive and statistical analyses. These include percentage growth rates and averages such as mean, mode and median computed were necessary.

In evaluating the benefit-incidence, the poverty line of the sample households was constructed. The poverty line is an analytical device for summarizing formation on source of income, consumption patterns, economic activities and living conditions. According to Ravallion and Bidan (1994), it shows how a measure of poverty varies access subgroups within a region or location (urban or rural). Also, the poverty line reveals differences in command over basic consumption needs. In essence, the proportion of the population below the poverty line provides a good indicator of the scope of the poverty in the society.

Following the works of Yusuf, et al (2002) and relying on Nigeria Human Development Report (HDR) (2008-2009) poverty index, the respondents were classified into poor and non-poor, with the formula:

$$Ha = \frac{1}{n} \sum_{i=1}^q \left[\frac{P - Mi}{P} \right] \dots \dots \dots (1)$$

where, P = predetermined poverty line; n = total sample; q = number of poor; Mi = per capita expenditure of the poor household i ; a = parameter that captures the poverty level.

In calculating the poverty line, the following steps were adopted. Firstly was calculate the total expenditure of each household for a year and then corrected for household size through adjustment by dividing total monthly expenditure of each household by household size as:

$$Mi = \frac{\sum^{ti}}{ni} \dots \dots \dots (2)$$

where Mi = per capita monthly expenditure of ith household; ti = total monthly expenditure of ith household on ith commodity group; ni = number of people in ith household.

Next, the mean per capita expenditure for ith population is computed as:

$$\bar{M}_i = \frac{\sum^{mi}}{N} \dots \dots \dots (3)$$

where, M = mean per capita expenditure for the population; n = total number of households sampled. On the basis of this, the households were divided into three categories using the following criteria: non-poor if $mi \geq 2/3m$; moderately poor if $1/3 \bar{m}_i < mi < 2/3 \bar{m}$; core pore if $mi < 1/3 m$

Then the group benefit-incidence of government expenditure on primary healthcare services was computed by employing the Demetry (2003) equation as stated below:

$$TXi = \frac{Hi Sc}{Hc} \dots \dots \dots (4)$$

where,
 TXi = value of the total health subsidy benefited by the people in economic group i
 Hi = total number of people in group I registered in public health centres;
 Sc = total subsidies provided by the government of the health centres;

H_c = total number of people registered in all the public health centres in the area.
Group i refers to household group, that is, non-poor, moderately poor and core poor in the society.

4. Presentation and Discussion of Results

Based on 110 samples, the socio-economic description of the respondents was taken and the results presented in Table 1. The result reveals that 86.7 percent of the respondents were male and 8.6 percent were female. Also 88.6 percent of the male and 76.8 percent of the female were married, while in either sex, the remaining people were single. Among the male, 24.6 percent attended primary school, 56.8 percent secondary school and 18.6 percent tertiary institution. In the female category, 29.2 percent, 58.2 percent and 12.6 percent respectively attended primary, secondary and higher institutions as shown in Table 2.

A further grouping of the respondents using occupation shows wide variation in the activities engaged by men and women. For instance, more men are involved in such activities as artisans and civil servants while more women are teachers and traders. In all, not many of the respondents are into government job as presented in Table 3.

Relaying in equation (3) above, the mean income for the entire household is deduced to be ₦9, 760.70. For educational attainment (that is, those who obtained primary, secondary and tertiary education), the mean incomes were ₦7, 500.00, ₦9,046.50 and ₦15, 140.80. The intuition from the above analysis is that income level increases as educational level increases.

Table 4 reveals that on the average, the respondents spend more food which gulps 58.8 percent of their total expenditure. This is followed by health which takes 31.3 percent of total expenditure. Expenditure on health was identified to include buying drugs for self medication or consultation with doctors. On the premise of an average household size of 6, the mean per capita expenditure of all the households is calculated to be ₦1, 402.40, implying that every member of the household in the sample survey is expected to spend at least ₦1, 402.40 per month. The households therefore, fall into those groups in table 5 based on the level of poverty.

In Table 5, about 46.4 percent of the respondents are poor, out of which 10 percent belong to the core-poor group. Table 6 shows that of the total sample that are non-poor, 8.4 percent used public health centres in contract to 6.3 percent of the moderately poor that used such service. The implication is that the core poor do not use public or private health service. This could be attributed to the notion that most of them use non-qualified attendants and uses herbal medicine. The table further shows that greater proportions of the sample used the private healthcare centres. This implies that public healthcare facilities are not very much relied upon by the respondents. Infact, about 86 percent of the respondents do not patronize public healthcare centres due to one or combination of the following reasons: incessant strikes, long waiting time caused mainly by the lackadaisical attitude of public health workers and poor equipment, as attested to by the respondents.

On the basis of the proportion estimated for the groups of public healthcare users in Table 6, the total people benefiting in the study area can be computed. Data from the public healthcare centres shows that a total of 26,009 people registered with the primary healthcare centres in 2010-2011, out of which about 27, 2004 are non-poor while 10,805 are moderately poor. Moreover, data from the accounts department of the local government reveal that in 2007, total government expenditure on the healthcare centres (including salaries and other expenses) was ₦69, 290, 420. This goes further to show that since 26,009 people registered, on the assumption that they all used the clinics equally; a total of ₦2, 66.09 was spent on every patient in 2007. The benefits accruing to each of the poverty groups can therefore be calculated as shown in table 6.

Table 7 reveal that the higher proportion of the subsidies on health services in Ika South Local Government Area accrues to the non poor household. This could be as a result of their ability to incur some expected expenses like purchase of drugs. The core poor did not benefit significantly perhaps because of the cost of purchasing drugs after consulting the doctors. It is expected therefore, that if health services are rendered free at the primary health centres, the poor would be motivated to derive some benefits from them. Table 8 below shows that average cost of households on publicly provided primary health centre.

The result shows that the average cost incurred by the non-poor in getting health services is higher than that for the moderately poor. The major area of disparity is drugs. The rich could be spending more because of their preference for quality drugs from reliable chemists. There could also be variation in price of drugs based on the type of disease being treated. The moderately poor spend more money on registration probably because they go to the clinic more often than the rich who may sometimes afford treatment at the private health centres. Table 8 further revealed that average cost incurred by the moderately poor in getting healthcare services was ₦322.65 while the non-poor incurred ₦623.10.

5. Conclusion

In this study, attempt has been made to analyze the welfare impact of government expenditure on healthcare services in rural Nigeria. To do this, the benefit-incidence approach was adopted based on sample generated from in Ika South Local Government Area of Delta state. The result revealed that household health expenditure in the form of self-medication and consultation with doctors represents about 31.3 percent of the total expenditure on basic needs item. On the basis of the head count poverty index, it is evident that about 10 percent belong to the core poor group while 36.4 percent of the household are poor. Only about 14 percent of all sampled households patronize public primary healthcare centres while about 43 percent patronize private healthcare providers. In this regard, there is low participation rate of households in government funded primary healthcare services even at that, the core-poor group cannot access the services. Thus, the benefit accrues only to the non-poor and the moderately poor. Since more non-poor access public primary healthcare services compared with their poor counterpart, it therefore implies that higher proportion of the benefit accrues to the non-poor. Evident from the above is that the poor are not sufficiently benefiting from the subsidies inherent in government expenditure on primary healthcare services. There is therefore the need for proper implementation of primary healthcare policies to make them more pro-poor. Since a major problem is non-affordability of most of the drugs by the poor, it is suggested that local government should collaborate with community for drug revolving scheme. This is to enable the poor have access to genuine drugs at affordable price. Moreover, there should be restructuring in public health expenditure pattern, focusing more on primary healthcare since this will benefit the poor. By so doing, their welfare would be greatly improved.

A major limitation of this study is the coverage. In this regard, it is suggested that further studies should be conducted to cover more local governments and possibly other states of the federation.

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Table 1: Socio-economic conditions of Respondents (Percentage)

	Male = 86.7	Female = 8.61
Marital status		
Married	88.6	75.8
Single	11.4	23.2
Educational attainment		
Primary	24.6	29.2
Secondary	56.8	58.2
Tertiary	18.6	12.6

Source: Author’s Field Survey

Table 2: Occupational Distribution of the Respondents

Category	Male (%)	Female (%)
Artisans	47.8	20.2
Civil Servants	8.3	7.8
Teachers	8.6	15.3
Traders	35.3	56.7

Source: Author’s Field Survey

Table 3: Average expenditure of Households on Some Basic Needs

Item	Average expenditure (N)	% of total Expenditure
Food	4,500.00	58.8
Housing	1,000.70	13.1
Clothing	750.00	9.8
Health	1402.40	31.3
Total	7653.10	100.0

Source: Computed from Authors Field Survey Data,

Table 4: Household Poverty Classification

Group	Mean per capita expenditure	Frequency	%
Non-poor	> 934.9	59	53.6
Moderately poor	468-934.9	40	36.4
Core-poor	< 467.5	11	10.0
Total		110	100.0

Source: Computed from Authors Field Survey Data,

Table 5: Number of Household using public and private Healthcare centres

Group	Public Health Users	% of Total	Private Health Users	% of Total	Estimated Population Users
Non-poor	8	6.3	10	10.5	15,204
Moderately poor	6	8.4	33	34.7	10,805
Core-poor	-	-	-	-	-
Total	14		43		26,009

Source: Computed from Authors Field Survey Data

Table 6: Benefit-Incidence of Health Sending by Group

Group	Number benefiting	Value of Benefit (N)
Non-poor	15,2004	40,504,824.36
Moderately poor		28,785,492.45
Core-poor	-	-

Source: Computed from Authors Field Survey Data,

Table 7: Average Cost of Households on Publicly provided Primary Health Centre (N/Patient)

Group	Drugs	Registration	Consultation	Total/Individual
Non-poor	505.10	87.5	30.5	623.10
Moderately poor	122.25	120.4	-	322.65
Core-poor	-	-	-	-

Source: Computed from Authors Field Survey Data,

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